BQIS POST-TRANSITION QA CHECKLIST

BQIS POST-TRANSITION QUALITY ASSURANCE CHECKLIST

Name of individual:	Names of BQIS/BDDS staff performing this checklist (print):
New Residential Provider:	Signature of BQIS/BDDS Representative completing this form:
Home Address & Phone #:	Date of visit for transition QA Checklist:_____ Check one: 7-day ☐ 30-day ☐ 60 -day ☐ 90-day ☐ other ☐
Setting: SL ☐ SGL☐ Other (describe below):	Name & phone # of Case Manager (SL) QMRP (SGL):
Date resident moved into home:	Name & phone # of Residential Provider contact person:
Previous Residential Provider/SOF:	Date of Individual Support Plan used for this checklist:

- **Prior to conducting the survey** – check to see if any incidents have been reported; attach a copy of those incidents and follow up to this survey form. Note in question 45 if any incident reports do not have appropriate follow up submitted.
- For the 7-day post-move visit, the existing ISP should still be in place regardless of type of placement setting. For the 30 day post-move visit, at a minimum, a meeting should be scheduled to review the existing ISP for Individuals moving into supported living setting, and an IPP should be in place for Individuals moving into group homes. All questions below are to be scored using the **current** support plan (supported living) or individual program plan (group home) for the resident:

"Yes" = compliance with plan "No" = not in compliance with plan "N/A" = not a need in plan

NOTE: All "No" responses must include a narrative explaining the deficit

		Yes	No	NA
1	Personal belongings in the home and available to Individual?			
2	Home adaptations in place? (list adaptations per PCP/ISP)			
3	Is an emergency telephone list present?*(N/A for Nursing Home Placement)*			
4	Medical equipment present (ex: G-tube, C-pap, Oxygen)? (list equipment per PCP/ISP)			
5	Adaptive equipment present (mealtime equipment, communicative devices, braces etc.)? (list equipment per PCP/ISP)			
6	Home clean and hygienic?			
7	Safe storage of medications, cleaning supplies, knives and other potential hazards? *(N/A for Nursing Home Placement)*			

BQIS POST-TRANSITION QUALITY ASSURANCE CHECKLIST

Name of Individual Transitioning: _____ Date of checklist visit: _____

8	House, lot, yard, garage, walks, driveway, etc. free of environmental hazards? *(N/A for Nursing Home Placement)*			
9	Hot water no warmer than 110º Fahrenheit (or documentation of safeguards in place to ensure that the individual is not at risk for scalding)?*(N/A for Nursing Home Placement)*			
10	Support plan updated? (enter date/time ISP meeting held. If planned & not yet held, enter date planned) *(N/A for Nursing Home Placement)*			
11	Transportation needs met? (describe how transportation needs are being met) *(N/A for Nursing Home Placement)*			
12	Are all issues identified as "High Risk" addressed appropriately? (list individual risk issues)			
13	Day program needs met? *(N/A for Nursing Home Placement)*			
14	Other programs/training (other than day programs) relevant and functional? *(N/A for Nursing Home Placement)*			
15	Opportunities for leisure relevant and promote independence? *(N/A for Nursing Home Placement)*			
16	Opportunities for community experiences? *(N/A for Nursing Home Placement)*			
17	Activities of Daily Living documented? *(N/A for Nursing Home Placement & SGL setting)*			
18	Data collection processes in place and consistently completed? *(N/A for Nursing Home Placement)*			
19	If medications have been changed, is there documented justification for the changes? (list changes including dosages pre and post change. Include date of change)			
20	Medication administered and charted appropriately?(for Nursing Home placement, see guidelines)			
21	PRN Psychotropic medications reported and documented? *(N/A for Nursing Home Placement)*			
22	Adequate staff assigned and present? (describe staffing ratios)*(N/A for Nursing Home Placement)*			
23	Staff trained on Individual's medical needs including side effects of medications?			

BQIS POST-TRANSITION QUALITY ASSURANCE CHECKLIST

Name of Individual Transitioning: _____ Date of checklist visit: _____

24	Staff trained on Individual's dietary/nutritional needs?			
25	Staff trained on Individual's personal hygiene needs?			
26	Staff trained on Individual's mobility needs?			
27	Staff trained on programs for Individual's behavioral considerations and/or psychiatric needs/symptoms?			
28	Staff trained on Individual's communication needs?			
29	Personal Physician identified and appointment scheduled?(enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*			
30	Personal Dentist identified, and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*			
31	Psychiatrist identified, and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*			
32	Neurologist identified, and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*			
33	Other Medical Specialist identified and if appropriate, appointment scheduled and kept? (enter specialty, name, phone # & appointment date/time. *(N/A for Nursing Home Placement)*			
34	Behavior Support provider identified and appointment scheduled and kept? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*			
35	OT/PT provider identified and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*			
36	Speech Language Pathologist provider identified, and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*			
37	Dietician identified and if appropriate, appointment scheduled and kept? (enter name, phone # & appointment date/time) *(N/A for Nursing Home Placement)*			
38	Is the Individual adjusting to the home (i.e. - Is there a lack of any observed or reported problems such as poor eating, sleeping disturbance, depression, etc)?			
39	If there have been any recent illnesses, injuries or hospitalizations, were they adequately and appropriately documented in the Individual's personal file? (list illnesses with dates) *(N/A for Nursing Home Placement)*			

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40	If there have been any recent illnesses, injuries or hospitalizations, did the Individual receive appropriate medical care including follow-up? *(N/A for Nursing Home Placement)*			
41	If there has been a change in home, provider or Case Mgr., has the change resulted in positive outcomes for the Individual? *(N/A for Nursing Home Placement)*			
42	Does interview &/or documentation indicate adequate involvement from the Case Manager, if on waiver? *(N/A for Nursing Home or SGL Placement)*			
43	Does a review of the documentation indicate that the BDDS Incident Reporting Policy is being followed? (If no – document dates and types of incident on this form and assure that the incident is filed per the BDDS Incident and file an incident regarding the non-reporting of the initial incident.) *(N/A for Nursing Home Placement)*			
44	Are all reported incidents resolved appropriately? *(N/A for Nursing Home Placement)*			
45	Are all needs (with emphasis on High-Risk needs) addressed at out-of-home habilitation service locations, including documentation of communication between the residential provider and providers at the out-of-home locations?			

Participants (with titles):

Notes:

CORRECTIVE ACTION RESPONSES FOR DEFICIENCIES NOTED

Name of Individual Transitioning: _____ Date of checklist visit: _____

Item #	Detailed explanation of deficit	Corrective Action Plan (includes specific actions planned; names of people contacted and dates/times of contact; targeted date for completion	Target Date for Action	Entity Responsible for Action	Date resolved	Resolution verified by:

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